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COUNTY OF LOS ANGELES

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January 21, 2016

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TO:

PATRICK OGAWA

Acting Executive Officer

Executive Office Board of Supervisors

Attention: Agenda Preparation

FROM:

PATRICK A. WU

Senior Assistant County Counsel

Executive Office

RE:

Item for the Board of Supervisors' Agenda

County Claims Board Recommendation

Alice Stockton v. County of Los Angeles, et al.
United States District Court Case No. CV 14-5764

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary and Summary Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary, and Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

PAW:cs

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled <u>Alice Stockton v. County of Los Angeles, et al.</u>, United States District Court Case No. CV 14-5764 in the amount of \$375,000 and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Sheriff's Department's budget.

This wrongful death lawsuit concerns allegations of excessive force arising from a shooting by a Sheriff Deputy.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME

Alice Stockton v. County of

Los Angeles, et al.

CASE NUMBER

CV 14-5764

COURT

United States District Court

DATE FILED

Claim filed April 2, 2014 Complaint filed July 24, 2014

COUNTY DEPARTMENT

Los Angeles County Sheriff's

Department

PROPOSED SETTLEMENT AMOUNT

\$ 375,000

ATTORNEY FOR PLAINTIFF

Brian T. Dunn, Esq. The Cochran Firm

COUNTY COUNSEL ATTORNEY

Jonathan McCaverty

NATURE OF CASE

This is a recommendation to settle for \$375,000, the lawsuit filed by Alice Stockton against the County of Los Angeles alleging federal civil rights violations for excessive force and related State-law claims for wrongful death stemming from the shooting of her son Darrell Atkinson.

Due to the risks and uncertainties of litigation, a reasonable settlement at this time will avoid further litigation costs. Therefore, a full and final settlement of the case in the amount of \$375,000 is recommended.

PAID ATTORNEY FEES, TO DATE	\$	28,874
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PAID COSTS, TO DATE \$ 8,194

Summary Corrective Action Plan



The intent of this form is to assist departments in writing a corrective action plan summary for attachment to the settlement documents developed for the Board of Supervisors and/or the County of Los Angeles Claims Board. The summary should be a specific overview of the claims/lawsuits' identified root causes and corrective actions (status, time frame, and responsible party). This summary does not replace the Corrective Action Plan form. If there is a question related to confidentiality, please consult County Counsel.

Date of incident/event:	Sunday, October 6, 2013, approximately 3:45 p.m.	
Briefly provide a description of the incident/event:	Alice Stockton, et al. v. County of Los Angeles, et al. Summary Corrective Action Plan No. 2015-032	
	On Sunday, October 6, 2013, at approximately 3:45 p.m., two uniformed Los Angeles County deputy sheriffs, assigned to the Los Angeles County Sheriff's Department's Transit Services Bureau (currently known as Transit Policing Division), were parked in their standard, black and white patrol vehicle when they saw the decedent acting suspiciously as he crawled on the ground behind a line of several shopping carts.	
	One deputy sheriff exited the patrol vehicle and contacted the decedent. The deputy sheriff could not see the decedent's hands, as his view was blocked by the shopping carts. The deputy sheriff asked the decedent to show him his hands several times, but the decedent refused.	
	The decedent armed himself with a wooden club and angrily yelled at the deputy sheriff. The deputy sheriff pointed his firearm at the decedent and ordered him to drop the club. The decedent raised the club and quickly advanced in the direction of the deputy sheriff. The deputy sheriff retreated while ordering the decedent to drop the weapon. The decedent continued to advance and closed the distance between the two of them.	
·	The deputy sheriff continued to retreat until he felt that he was about to fall backwards off the curb and into traffic. Fearing for his safety, the deputy sheriff discharged three rounds from his Department-issued duty weapon at the decedent. This appeared to have no effect on the decedent as he continued to advance on the deputy. The deputy sheriff disharged three additional rounds, striking the decedent (Exhibit A - Los Angeles County Sheriff's Department Manual of Policy and Procedures section 3-10/200.00 Use Of Firearms And Deadly Force).	
	The decedent was transported to a local hospital where he was pronounced dead.	

1. Briefly describe the root cause(s) of the claim/lawsuit:

The **primary** root cause in this incident was the decedent's failure to follow the orders of a Los Angeles County deputy sheriff to drop his weapon and discontinue his aggressive advance toward the deputy sheriff. The decedent's actions caused a member of the Los Angeles County Sheriff's Department to deploy deadly force.

An associated **primary** root cause in this incident was the decedent's mental health issues. The decedent was a combat veteran diagnosed with post-traumatic stress disorder. The decedent reportedly walked away from his family and his mental health treatment in Texas and came to live as a transient in the Los Angeles area.

A **secondary** root cause in this incident was that a Taser, or other less-lethal option, was not utilized. When the decedent armed himself with a weapon capable of great bodily injury, the first deputy drew his firearm, foreclosing on the opportunity to deploy (or even consider) a less-lethal option. As a result, when posed with a perceived potentially life-threatening attack, the first deputy shot the decedent with his firearm to stop the attack.

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

Initiation and Completion of a Criminal Investigation

The Department had relevant policies and procedures/protocols in effect at the time of the incident.

The Department's training curriculum addresses the circumstances which occurred in the incident.

This incident was thoroughly investigated by representatives from the Los Angeles County Sheriff's Department's Homicide Bureau to determine the extent to which one or more members of the Los Angeles County Sheriff's Department engaged in *criminal* misconduct.

The results of their investigation were presented to representatives from the Los Angeles County District Attorney's Office. On September 24, 2014, the Los Angeles County District Attorney's Office concluded "that (the deputy sheriff) was placed in reasonable fear of imminent danger of death or great bodily injury by (decedent's) actions and acted lawfully in self-defense when he used deadly force."

Initiation and Completion of an Administration Investigation

Following the criminal investigation by the Los Angeles County Sheriff's Department's Homicide Bureau, the incident was then investigated by the Los Angeles County Sheriff's Department's Internal Affairs Bureau to determine the extent to which one or more members of the Los Angele County Sheriff's Department engaged in *administrative* misconduct.

On August 20, 2015, the results of the administrative investigation were presented to the members of the Los Angeles County Sheriff's Department's Executive Force Review Committee. The Committee concluded the use of force was objectively reasonable and consistent with Department policy and tactics.

Re-Training

Although the members of the Executive Force Review Committee concluded the use of force was objectively reasonable and consistent with the Department's policy and tactics, they recommended that both deputy sheriffs participate in eight hours of tactics and survival training and eight hours of training handling individuals with issues related to mental health.

The deputy sheriffs attended a tactics and survival training class on September 16 and 17, 2015. They attended a Dealing with Mentally III for Law Enforcement training class on July 22 and September 21, 2015.

Counseling and De-Briefing

The members of the Executive Force Review Committee also recommended that the deputy sheriffs' unit commander conduct a thorough tactical debriefing with the deputy sheriffs to fully examine the important components of the incident.

The de-briefing occurred on September 21, 2015. Vital components of the debriefing included (but were not limited to) general officer-safety issues, placing oneself in precarious situations while on or off duty, and utilizing relevant training and experiences.

No other employee misconduct is suspected, and no systemic issues were identified. Consequently, no further personnel-related administrative action was taken, and no other corrective action measures are recommended nor contemplated.

Mental Health Awareness and Development

In November of 2014, the Department began participation in a mental health task force entitled, "Investment in Mental Health." This working group meets approximately once per month and consists of representatives from the Department, the Los Angeles County District Attorney's Office, the Los Angeles County Department of Mental Health, the Department's Employee Support Services, and the Office of the Inspector General.

The group was empaneled to (among other objectives) (1) explore the mental health industry's best practices; (2) develop strategies for providing responsive, compassionate service(s) to those with some level of confirmed or suspected mental illness; (3) develop, refine, and implement relevant training for members of the Los Angeles County Sheriff's Department; and (4) explore funding sources to expand crisis intervention training to 40 hours, and strengthen the Department's crisis intervention business model to include the creation of a Mental Health Bureau (commanded by a captain and supported by appropriate staff) and the expansion of mental evaluation teams available in the field.

Mental Health Training

The "Investment in Mental Health" Task Force is collaborating with the Department of Mental Health to improve patrol response to mental illness related contacts and incidents. As a result, the Department has implemented several programs to educate personnel. Several layers of training have been implemented with further expansion within this fiscal budget year.

A mandated Peace Officer Standards and Training Mental Illness update training video has been distributed and, as of this report, 2,454 patrol personnel (49.9%) have completed the training. The Department expects all patrol personnel to have completed this training by July, 2016.

A non-mandated, eight-hour "Law Enforcement and Effective Interaction with Mentally III" training course is available, and attendance is highly encouraged by division chiefs. As of this report, 263 personnel have attended this training, and new classes continue to be scheduled.

A 40-hour "Mental Health Crisis Intervention for Patrol" training class has been funded, is in the development, and is expected to commence in January, 2016.

Mental Health Evaluation Team Expansion

As of July 2015, the Department increased the staffing and deployment of their field mental health crisis intervention Mental Health Evaluation Teams from five to eight (the most the Department has ever had deployed).

Based on the "Investment in Mental Health" Task Force's assessment, evaluations, and recommendations, the Los Angeles County Board of Supervisors approved funds that will allow the

Department to further increase the number of mental health crisis intervention Mental Health Evaluation Teams from eight to 23 by the end of Fiscal Year 2015-2016.

Mental Health Resource Material

There were several mental health information resources throughout the Department that gave guidance on how to deal with different scenarios involving mentally ill persons. Based on the "Investment in Mental Health" Task Force's recommendations, the Department has re-evaluated and consolidated the information into a single source material for personnel.

The Department's Field Operations Support Services (FOSS) is in the final approval process of a new FOSS Newsletter entitled "Engaging the Mentally III." This resource material is being designed to help Department personnel:

- · Better recognize symptoms and behaviors associated with mental illness
- Develop communication and engagement skills that make handling situations with the mentally ill more effective

Additionally, the Department has created a new mental health informational pocket pamphlet entitled "LASD Cares." This pamphlet is designed for family members of mentally ill persons. It describes the 5150 WIC (72-hour hold) process and provides information regarding other mental health resources (see LASD Cares Pamphlet in **Exhibit B**).

Less-Lethal Options

During the incident, the first deputy did not have a TASER device on his person, but he did have other less-lethal options. The second deputy sheriff did have a TASER on his person in addition to other available less-lethal options. The deputy sheriffs also had a less-lethal stunbag shotgun in the trunk of their vehicle.

Even if the first deputy sheriff had a TASER or other less-lethal options, the necessity to re-holster his firearm in order to retrieve a less-lethal option makes it a non-practical option.

Based on the rapid progression of the situation, the suspect's distance from the first deputy, the likelihood of the decedent's attack having the ability to cause severe injury or death to the first deputy, a less-lethal option was not practical in this situation.

It is practical that the second deputy sheriff could have assessed the decedent's threat and either applied deadly force or utilized an available less-lethal option. By the time the second deputy sheriff exited his vehicle and began to get involved in the incident, the shooting had already occurred.

Department policy regarding the possession and deployment of less-lethal options is regulated by existing Department policy (Exhibit C – Los Angeles County Sheriff's Department's Manual of Policy and Procedures section 5-06/040.05 Use of Less Lethal Weapons, and section 5-06/040.95 Electronic Immobilization Device [Taser] Procedures).

3: Are the corrective actions addressing department-	wide system issues?
☐ Yes – The corrective actions address department	nt-wide system issues
☑ No – The corrective actions are only applicable to the corrective actions. ☐ No – The corrective actions are only applicable. ☐ No – The corrective actions are only applicable. ☐ No – The corrective actions are only applicable. ☐ No – The corrective actions are only applicable. ☐ No – The corrective actions. ☐ No – The corrective actions are only applicable. ☐ No – The corrective actions. ☐ No –	
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Los Angeles County Sheriff's Department	
Name: (Risk Management Coordinator)	
Scott E. Johnson, Captain Risk Management Bureau	
Signature:	Date:
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l. fr. 145028	11-6-15
Name: (Department Head)	
Karyn Mannis, Chief	
Professional Standards Division	
Signature:	Date:
Kama Manns	12-18-15
Objection of the Control of the Cont	
Chief Executive Office Risk Management Inspector G	
Are the corrective actions applicable to other departments	s within the County?
☐ Yes, the corrective actions potentially have Cou	inty-wide applicability
No, the corrective actions are applicable only to	
Name: (Risk Management Inspector General)	
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Signature:	Date:
	and the second
STE.NB!	12-27-15

EXHIBITS

EXHIBIT A



3-10/200.00 USE OF FIREARMS AND DEADLY FORCE

The Department's policy on use of firearms and deadly force is:

- discharging a firearm at another human being is an application of deadly force and must, therefore, be objectively reasonable. Each Department member discharging a firearm must establish independent reasoning for using deadly force. The fact that other law enforcement personnel discharge firearms is not by itself sufficient to justify the decision by a Department member to shoot;
- Department members may use deadly force in self-defense or in the defense of others, only when they reasonably believe that death or serious physical injury is about to be inflicted upon themselves or others;
- Department members may use deadly force to effect the arrest or prevent the escape of a fleeing felon only when they have probable cause to believe that the suspect represents a significant threat of death or serious physical injury to the member or other person(s). If feasible, members shall identify themselves and state their intention to shoot before firing at a fleeing felon;
- the firing of warning shots is inherently dangerous. They should not be fired except under the most compelling circumstances. Warning shots may be fired in an effort to stop a person only when the Department member is authorized to use deadly force, and if the member reasonably believes a warning shot can be fired safely in light of all the circumstances of the encounter; and
- cover fire is defined as target specific controlled fire which is directed at an adversary
 who poses an immediate and on-going lethal threat. This tactic shall only be utilized
 when the use of deadly force is legally justified. Target acquisition and communication
 are key elements in the successful use of this tactic. Department members employing
 cover fire must establish their reason(s) for utilizing this tactic.

Revised 07/12/13
Revised 12/19/12 (Implementation January 1, 2013)
Revised 06/13/05
Revised 05/16/05
04/01/96 MPP

EXHIBIT B

Law enforcement agencies around the nation, including LASD, have developed training on ways to deal with individuals with mental illness. Tips from that training include:

Have Time, Go Online-Visit www.HealthyCity.org

Hours: Online, anytime Referrals specific to your zip code



- Speak calmly and quietly.
- Keep a reasonable distance. Remember your personal safety.
- Do not take the individual's strong language personally.
- Respond to rage with quiet reassurance. Slow down the pace.
- Be willing to repeat yourself.
- Listen carefully and do not interrupt. Be respectful.
- Do not challenge the individual. Make no sudden moves.
- Do not try to hurry the resolution.
- Be patient and take your time.



Los Angeles County

Sheriff's Department

211 West Temple Street Los Angeles, CA 90012

www.lasd.org

With Mental Illness

1. Life Threatening Emergency - Dial 9-1-1

Call 24 hours a day in case of an extreme emergency if you, your loved one and/or the public are facing an imminent threat.

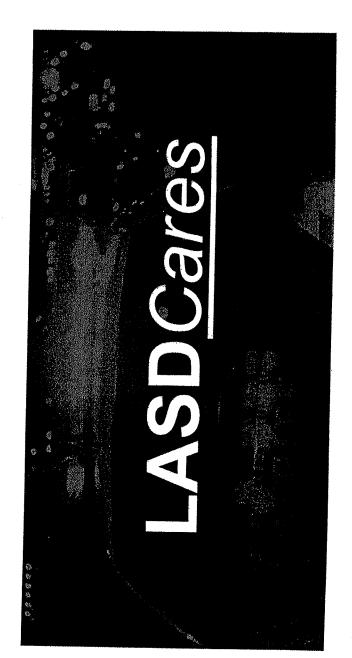
2. Urgent Questions - call the DMH ACCESS Center (800) 854-7771 Call: 24 hours a day

Response Team won't come out right away, it may take a few hours, so if the situation changes to If you need help with a situation that seems to be getting worse, but hasn't turned into an emergency, call the DMH Access Center. They will discuss resources and if necessary, may send a Psychiatric Mobile Response team to your location to help evaluate the situation. However, the an emergency, dial 911 immediately.

3. Start a Caregiver Plan - Dial 2-1-1

Call: 24 hours a day

211 LA County provides access to comprehensive social services and disaster support for Los thoughts, hallucinations, or what to do when your loved one becomes gravely disabled. After a Angeles County residents. They work closely with the DMH ACCESS Center on mental health resources. They can help you with questions about your loved one's behavior such as suicidal series of telephone prompts, you will speak to a live person.



4. Who Qualifies for a '5150' Hold?

Under certain circumstances, officers can place your loved one on a 5150 Hold. This means a mentally ill person is held for at least 72-hours at a hospital while being evaluated. This can only be done when (1) the individual presents a danger to himself or others, or (2) a person is so disabled that he or she cannot take care of daily life activities (for example, has stopped eating for days and won't come out of the bedroom). However, this is a very difficult standard to meet. In most cases, the LASD cannot take your loved one to a hospital against his or her will.

5. Crisis Lines:

Suicide Prevention and Survivor Hotline: (24 hours/7 days)

Calling from Los Angeles, Orange, Ventura, San Bernardino, Riverside and Imperial Counties:

English: 877-727-4747

Spanish: 888-628-9454

Calling from outside the above counties: • (310) 391-1253

Substance Abuse Hotline:

(800) 564-6600 Veterans Services:

(877) 452-8387

National Alliance on Mental Illness (NAMI):

(800) 950-NAMI (6264) www.nami.org Los Angeles Gay and Lesbian Center: (323) 993-7400



5-06/040.05 USE OF LESS-LETHAL WEAPONS

Only qualified Department personnel, who have successfully passed Department training and are currently certified in the use of the weapon, shall carry a less-lethal weapon. Less-lethal weapons include, but are not limited to, the following devices covered under this section:

- · Baton Launching Systems;
- Electro-Muscular Disruption Devices (Taser);
- 12-Gauge stunbag;
- · Pepperball launchers, Noise/Flash Diversionary Devices; and
- chemical agents (small aerosol containers).

Personnel carrying a less-lethal weapon system shall record the weapon's information per divisional directive (i.e., MDT/MDC entry, armory sign out log, or any other means a unit has adopted for accounting for these weapons).

The use of a less-lethal weapon will be at the discretion of the individual Deputy. Deputy personnel encountering a situation which may require the use of a less-lethal weapon system, when feasible, will immediately notify a supervisor.

Guidelines for the use of less-lethal weapon platforms fall under the "Situational Use of Force Options Chart." All Department personnel utilizing these weapons must do so only when objectively reasonable given the circumstances and shall be governed by MPP section 3-10/100.00, "Use of Force Review and Reporting Procedures."

Revised 12/12/13 Revised 11/03/08 Revised 06/04/04 04/01/96 MPP



5-06/040.95 ELECTRONIC IMMOBILIZATION DEVICE (TASER) PROCEDURES

The TASER is a less lethal hand held electronic immobilization device used for controlling assaultive/high risk persons. The purpose of this device is to facilitate a safe and effective response in order to minimize injury to suspects and deputies.

Use of the Electronic Immobilization Device (TASER)

The following policy guidelines shall be adhered to:

- only a Departmentally approved TASER shall be utilized by personnel;
- a TASER shall be issued to and used only by those personnel who have completed the Department's TASER Training Program;
- personnel authorized to carry a TASER on duty, may purchase a Departmentally approved TASER for on and off duty use;
- prior to the use of the TASER, whenever practical, Department personnel shall request a supervisor;
- any individual subjected to an application of the TASER, in either the "probe" or the "touch/drive stun" mode, shall be taken to a medical facility prior to booking, for appropriate medical treatment and/or removal of the probes; and
- application of the TASER shall be discontinued once the suspect does not pose an immediate threat to themselves, Department personnel or the public.

Except in emergent circumstances, the TASER should not be applied to the following or used in any other situation where there is a reasonably foreseeable likelihood of severe injury or death. In the extraordinary instance that Department personnel feel compelled to utilize the TASER in the following circumstances, the conduct of the involved personnel shall be evaluated in accordance to the Use of Force policy with sound tactical principles.

- · handcuffed persons;
- persons detained in a police vehicle;
- persons detained in any booking or holding cell;
- persons in control of a motor vehicle;
- persons in danger of falling or becoming entangled in machinery or heavy equipment which could result in death or serious bodily injury;
- persons near flammable or combustible fumes;
- persons near any body of water that may present a drowning risk; and
- persons known to have a pacemaker or known to be pregnant.

The Custody Division Manual may define criteria for a unique application of the TASER within a custodial setting.

Verbal Warning

Unless it would compromise officer safety or is impractical due to circumstances, a verbal warning of the intended use of the TASER shall precede the activation of the device in order to:

- provide the individual with a reasonable opportunity to voluntarily comply; and
- provide other sworn personnel and individuals with a warning that a TASER may be activated.

The fact that a verbal and/or other warning was given or reasons it was not given shall be documented in any related reports.

Authorized Department personnel discharging a TASER shall request the response of a supervisor if not already en route or on-scene.

Reporting the Use of the Electronic Immobilization Device (TASER)

The use of the TASER, either by utilizing the probes or the touch/drive stun mode, shall be reported as a "significant" use of force as defined in the Department Manual of Policy and Procedures, section 3-10/100.00, "Use of Force Reporting and Review Procedures."

Whenever a use of a TASER requires force reporting, a download of the TASER stored data and video shall be conducted and submitted with the force package.

Personally Owned Electronic Immobilization Devices (TASER)

Authorized Department personnel shall only carry Department authorized Electronic Immobilization Devices (TASER) whether on or off-duty.

Personally owned TASERs shall be available for computer download upon the request of a supervisor. The device shall meet the specification of the Weapons Training Center, and shall only be used in accordance with this section.

Department personnel shall record all personally owned Department-authorized TASERs (carried on-duty and off-duty) with Personnel Administration when the devices are purchased or obtained, sold or disposed of, stolen or lost.

Revised 12/12/13 Revised 06/20/11 Revised 02/07/11 Revised 11/03/08 Revised 08/10/05